EXHIBIT 15

UNITED STATES DISTRICT COURT

DISTRICT OF MASSACHUSETTS

NO. 01CV12257-PBS

In re: PHARMACEUTICAL)
INDUSTRY AVERAGE WHOLESALE)
PRICE LITIGATION)
)
THIS DOCUMENT RELATES TO:)
ALL ACTIONS)

DEPOSITION of DEBORAH DEVAUX, called as a witness by and on behalf of Johnson & Johnson, pursuant to the applicable provisions of the Federal Rules of Civil Procedure, before P. Jodi Ohnemus, Notary Public, Certified Shorthand Reporter, Certified Realtime Reporter, and Registered Merit Reporter, within and for the Commonwealth of Massachusetts, at the offices of Robins, Kaplan, Miller & Ciresi, L.L.P., 800 Boylston Street, Boston, Massachusetts, on Thursday, 9 March, 2006, commencing at 9:35 a.m.

EXHIBITS

EXHIBIT	DESCRIPTION	PAGE
Exhibit Devaux 001	"Analysis of CMS Average Wholesale Price Reform, 2/7/04, with handwriting	155
Exhibit Devaux 002	"Analysis of CMS Average 2/7/04	155
Exhibit Devaux 003	Memo, 11/6/92	220
Exhibit Devaux 004	"Hooked on Drugs"	230
Exhibit Devaux 005	Prescription Drug Study, April 1994	237
Exhibit Devaux 006	BCBSMA-AWP 12496-12500	263
Exhibit Devaux 007	BCBSMA-AWP 12611-12612	273
Exhibit Devaux 008A	BCBSMA-AWP 005188-005205	278

Exhibit Devaux 008B	BCBSMA-AWP 005206-5222	279
Exhibit Devaux 008C	BCBSMA-AWP 005223-5239	279

VIDEO OPERATOR: We are now recording and on the record. My name is George Libares. I'm a Certified Legal Video Specialist for Henderson Legal Service. Today is March 9th, 2006, and the time is 9:36 a.m.

This is the deposition of Deborah Devaux, in re: The pharmaceutical industry average wholesale price litigation, in the United States District Court, District of Massachusetts, Case No. 01CV12257-PBS.

This deposition is being taken at 800 Boylston Street, in Boston, Massachusetts. The court reporter is Jodi Ohnemus. Counsel will now state their appearances and the court reporter will administer the oath.

MR. MANGI: Adeel Mangi from Patterson, Belknap, Webb & Tyler Patents for Johnson & Johnson.

MR. COCO: Steven Coco from Robins, Kaplan, Miller & Ciresi for Blue Cross Blue Shield of Massachusetts.

MR. NOTARGIACOMO: Ed Notargiacomo from

Hagens, Berman, Sobol & Shapiro for the class Plaintiffs.

MR. SKWARA: Steve Skwara for Blue Cross Blue Shield of Massachusetts.

DEBORAH L. DEVAUX,
having first been duly sworn,
testified as follows to
direct interrogatories

BY MR. MANGI:

Q. Ms. Devaux, could you state your full name for the record, please.

A. Yes. It's Deborah Devaux.

Q. Are you currently employed?

A. Yes.

Q. Who do you work for?

A. Blue Cross Blue Shield of Massachusetts.

Q. And what is your current title?

A. Senior vice president for health care contract management.

Q. How long have you held that position?

A. I've been at Blue Cross for five and a half years. I can't remember exactly when I was

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talk about reimbursement for drugs -- AWP; what it is, what it isn't.
A. Yeah.
Q. Who, to your knowledge, at BCBS are people that are familiar with that benchmark? Who knows about it?
MR. COCO: Objection.
A. I don't know everybody at Blue Cross Blue Shield who's familiar with that.
Q. Right. Right. My question --
A. Certainly, John Killion in my group is familiar with the concept of AWP and of drugs as related to physician office.
Q. So, if -- if you had a question about AWP, if you wanted to know more about it, John Killion would probably be one of the people you would go and talk to?
MR. COCO: Objection.
A. It depends on the question.
Q. Well, if you wanted to gain a general understanding of AWP, what is it, what isn't it, would you go and talk to Mr. Killion or someone

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else?
MR. COCO: Objection.
A. I don't know. I don't know.
Q. Well, Mr. Killion is the only person you've identified so far who you think --
A. Yeah.
Q. -- may be knowledgeable about it, right?
A. Right. But it depends on the question. I mean, we have other people in the organization that know about reimbursement. I also might talk to our pharmacy benefits manager, Express Scripts, about the question.
Q. Uh-huh.
A. And/or might end up, you know, just doing research on the internet. I am -- in other words, I'm not saying I would have a knee-jerk reaction. It would kind of depend on what the issue was.
Q. Okay. So, let's look at the range of possibilities. Let's say you decided tomorrow you wanted to learn more about AWP. One option would be to talk to someone at BCBS, of whom John Killion may be one option.

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MR. COCO: Objection.
A. Yeah.
Q. He's a person you've identified as probably knowledgeable about AWP.
A. Yeah, I might talk to him.
Q. Another option would be to talk to BCBS of Massachusetts' PBM, which is currently Express Scripts.
MR. COCO: Objection.
A. Yes.
Q. And the third option would be to go and research the issue, to look for what's publicly available, what's published about AWP.
MR. COCO: Objection.
A. Right.
MR. MANGI: This is a good time to take lunch, if you're suitably hungry.
THE WITNESS: Okay, sure.
VIDEO OPERATOR: The time is 12:30. We're off the record.
(Whereupon the deposition recessed at 12:30 p.m.)

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AFTERNOON SESSION (1:21 PM)
VIDEO OPERATOR: The time is 1:21 p.m. We're on the record.
Q. Ms. Devaux, are you familiar with the term "specialty pharmacy"?
A. Yes.
Q. Okay. What is your understanding of what a specialty pharmacy does?
A. My knowledge relates to the use of the term "specialty pharmacy" related to injectable drugs. I'm not sure if there are other drugs that are considered in the category of specialty pharmacy.
Q. What is your understanding of specialty pharmacy in that context?
A. In that context, it's that there are certain drugs that are often administered in a physician's office by injection and observed in a physician's office.
Q. All right. And what does a -- what is the role of a specialty pharmacy in relation to those drugs?

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A. Yeah.
Q. Now, earlier in the day I had asked you a question about specialty pharmacies, and in thinking about that, you had mentioned that you recalled a period when BCBS of Massachusetts considered whether to follow CMS as regards a change in methodology. Do you recall that testimony?
A. Yes.
Q. Okay. Does this document pertain to that issue?
A. Yes.
Q. Was that issue -- withdraw that. Are you familiar with the Provider Financial Strategy Work Group?
A. Yes.
Q. Are you a part of that work group?
A. Yes.
Q. What is the role of the Provider Financial Strategy Work Group?
A. The role of the work group is to consider issues related to reimbursement and incentive

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programs for the hospitals and physicians in our network.
Q. Now, previous witnesses have testified that this issue -- whether or not to shift to an ASP methodology -- was considered by that committee. That was the work group charged with looking at that issue, is that correct?
A. We did have one meeting about this issue, and I recall that this was the -- I believe it was the shorter version of this document was the handout for that meeting. I don't -- I don't recall seeing the attachments.
Q. So, by "shorter version," you're referring to the --
A. Exhibit Devaux 001.
Q. Okay, which is the same thing as Pages 1 through 16 of Exhibit Devaux 002.
A. Yeah. I -- I don't recall that there was this -- the attachment level of detail at the meeting, but I do recall looking at these options.
Q. Okay. Now, I'd like to ask you a few questions about this process and this issue.

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A. Uh-huh.
Q. And if you'd like to refer to the document at any point, please feel free to do so. Up until this time, and up until consideration of this issue, BCBS of Massachusetts had always followed Medicare's example in terms of the rate it reimbursed for drugs administered in physician' offices, as far as you're aware, right?
A. I don't know about always. I know that since I joined Blue Cross in 2000, it's been my understanding that we had followed Medicare on this.
Q. Now, when Medicare was contemplating a shift to ASP --
A. Uh-huh.
Q. -- why did BCBS consider whether or not it needs to do the same thing?
A. Because of the fact that we had generally followed Medicare as a standard.
Q. Were there any other reasons why BCBS was contemplating, in this 2003/2004 period, moving away from an AWP-based methodology?

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A. Not that I'm aware of.
Q. Okay. Now, I'd like you to turn, if you would, to Page 2 of the document.
A. Uh-huh.
Q. And this is a list of "Reasons For Reform." Do you see that?
A. Yes.
Q. Okay. Do you recall these issues being discussed at the meeting of the Provider Financial Strategy Work Group regarding this issue?
A. I don't specifically recall each of these issues, but I recall in general discussing why Medicare was considering moving in this direction.
Q. Okay. And what was your understanding of the reasons why Medicare was considering moving in this direction?
A. Because Medicare believed that they were overpaying for the drugs; that they were not paying a reasonable rate for the drugs.
Q. Okay. Anything else?
A. No.
Q. When you say you understood Medicare

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thought they were overpaying, is that related to the second bullet point we see on this, "Reasons For Reform" chart?
MR. COCO: Objection.
A. I don't recall exactly what the statements were that led to that, but my understanding was that that's what was causing Medicare to consider a change.
Q. And this document was actually used at the Provider Financial Strategy Work Group?
A. Yes.
Q. Okay. So, all of these points would have been considered by the group as a whole in reaching their decision?
A. There was certainly at the meeting. I don't recall discussing each point. But, yes, the handout would have been available to those attending.
Q. And one of the issues listed here is -- the first one on the list, "Physicians benefit from the spread between AWP and acquisition cost, creating an overpayment for drugs and costs for

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Medicare." Was this the first time you became aware of this particular issue, or were you familiar with it from before?
MR. COCO: Objection.
A. I don't recall. This is -- I don't recall. This is certainly the first time that I was involved in a decision about what would be done relative to Medicare.
Q. Okay. Now, it's fair to say, isn't it, that from your experience in the industry, going all the way back to your work at the New England Medical Center and other facilities, you understood that physicians generally are being reimbursed at reasonable cost plus a margin, right?
MR. COCO: Objection.
A. I don't like to make any general statements about physicians. I think there are wide variations, depending on the service and the circumstance.
Q. All right. Did you -- is it your understanding -- again, as a general matter -- that physicians were being reimbursed below their cost,

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at their cost, or at their cost, plus an additional amount?
MR. COCO: Objection.
A. I think that it varies by service, by physician, and by circumstance.
Q. Okay. Well, when you were at the New England Medical Center, certainly the New England Medical Center sought to attain reimbursement that was at reasonable cost plus a margin, right? We discussed that this morning.
A. Yes, they sought to attain that reimbursement, yes.
Q. And similarly, there's no reason to think other providers approached reimbursement issues any differently, right?
MR. COCO: Objection.
A. I don't like to attribute thinking to other providers that I might not have knowledge -- direct knowledge of.
Q. Let me put it this way then: Based on your own personal experience when you represented providers in negotiations or when you consulted

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with providers, it's certainly your own experience that providers would seek to be reimbursed at their reasonable cost plus a margin?
MR. COCO: Objection.
A. I think the complexity results in determining what a reasonable cost is and what a reasonable margin is. But yes, I think that providers do not want to be paid less than their acquisition cost or what they believe to be their service cost.
Q. This third bullet point here also notes that, "Oncologists collected approximately $600 million in overpayments." Do you recall any discussion of this issue at the -- at the meeting?
MR. COCO: Objection.
A. I don't. This is the kind of issue that wouldn't have registered with me, because if that's a national number, which it seems to be, I probably wouldn't have been as attuned to that as what's the effect on my members.
Q. Now, let's have a look at Page 5 of the document, please. Now, the first bullet here

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Q. Now, do you recall whether or not these numbers were discussed at the Provider Financial Strategy Work Group?
A. I don't recall the discussion specifically, but I know that the issue was discussed. I -- what I recall more clearly was the discussion of the options.
Q. Okay. And we'll come to that in a moment.
A. This -- in the context of the discussion of the options, not -- not this page in a -- in a vacuum.
Q. Now, looking just at the financial impact, this table charged that in terms of drugs only, moving to an ASP-based methodology would result in savings of over $10 million to BCBS on an annualized basis, right?
MR. COCO: Objection.
A. That's -- looking at this page, that's my understanding.
Q. Okay. It says that the administration fees for drugs would increase, so, you would -- BCBS would be paying $4 million more than it would

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before if it changed to follow CMS's methodology, right?
MR. COCO: Objection.
A. Yes.
Q. And the third row nets out those two figures and shows that if BCBS were to follow CMS's methodology, it would end up saving in excess of $6 million on an annualized basis, right?
MR. COCO: Objection.
A. Right.
Q. Okay. Now, earlier you mentioned that you recall there was a discussion regarding the appropriateness of payments for the drug -- I think you said appropriateness of payments for the drug itself. What did you mean by that?
MR. COCO: Objection.
A. My understanding of the basic driver for Medicare looking at this was a concern about the reasonableness of the -- the pricing -- the AWP relative to the acquisition cost. So, my understanding was that was what drove CMS to evaluate a change in payment for the drug.

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Q. Okay. And that's similar to the concern that you understand is grounding this litigation, correct?
MR. COCO: Objection.
A. I hadn't thought about the two connected.
Q. Okay. Well, I mean, let's -- let's think about it now. As you described it earlier, you understood this litigation was about the relationship between AWP and acquisition costs for drugs, right?
MR. COCO: Objection.
A. I think about how the AWP was set, yeah.
Q. Okay.
A. I think here I'm looking at it more through the lens of the effect of that on the -- the effect of that practice on the cost for the health plan.
Q. Okay. Now, looking at the next page, which is Page 8, what does this chart purport to show?
A. Actually, I don't remember this chart, so I'd have to spend some time looking at it, and I

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don't recall discussing this one at the meeting. (Witness reviews document.) So, your question was?
Q. What does this chart show?
MR. COCO: Objection.
A. On the surface, what I'd say is it's taking the top ten physician specialties that would be affected by the change that CMS was proposing, and trying to estimate the financial impact on each of those specialties in the aggregate.
Q. Okay. And why was this analysis of relevance to the determination of this issue?
A. I'd be speculating in hindsight, really. I think other than to say we -- in making any decision -- we always want to understand what the impact is going to be on the providers in our network so that it's not made in a -- in a vacuum. There's really an understanding about how it affects -- who it affects and how.
Q. And is that true as a general statement, before making any changes in reimbursement policy or methodology, Blue Cross Blue Shield wants to understand and give conversation to any concerns

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that providers may have?
MR. COCO: Objection.
A. It's a goal. I don't know if we always achieve that, but, yes, our goal would be to understand the implications of our decisions by under -- by looking at the impact on the affected providers.
Q. Now, let's turn to the options.
A. Yeah.
Q. I believe you -- you testified earlier that they -- you do recall discussion of -- of the options at the Provider Financial Strategy Work Group.
A. I do.
Q. Now, on Page 12, the first option that was considered is to follow CMS in all respects, both moving drug reimbursement to ASP, and changing admin fees like CMS was, right?
MR. COCO: Objection.
A. Right.
Q. Okay. What was discussed as regards the positives and negatives of taking that approach?

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A. I don't recall exactly what the discussion was. The major issue that has remained in my mind since this meeting two years ago was that the oncologists were stating -- were giving a lot of push-back to Medicare on this issue. So, the -- recollection about what registered in my mind was that some -- I got the impression that there was a significant amount of push-back, and that it was not clear that CMS was absolutely going to implement this as proposed.
Q. Why was the fact that oncologists were pushing back or showing resistance to this change in methodology relevant to consideration of whether or not to adopt Option 1?
A. Really, two reasons: One, we don't like to be in a position where we're whipsawing. So, if there was a risk that CMS would implement and then pull back or would not implement after stating that they would, we don't like to be in a position where we've made a decision or announced it or invested in changing our internal coding and payment policies, and then draw that back for the obvious,

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I guess, reasons.
Q. And that's what's reflected in the fourth bullet point under "Comments."
MR. COCO: Objection.
A. I'm not sure what the intent was. I just know that what registered -- of that bullet. I just know that what registered in my mind was that CMS was getting a lot of feedback on this issue, and this was not thought at this time to be a payment policy that was definitely going to remain in place. There was some question about that.
Q. Now, you mentioned there were two reasons, and that's the first.
A. Yeah.
Q. What's the second reason?
A. The second reason was that the oncologists had contemplated to a representative of Blue Cross that, in the event that CMS continued with this policy, they might shift -- they might stop providing this service in their office and put the patient in the middle by requiring that they go to a hospital to get this service, and that -- again,

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I don't remember the discussion, but I remember what registered in my mind is that -- that would not be beneficial to our members for two reasons: One, it may be less convenient for the member to get the service in a hospital open question.
But the other was that it would likely be more costly for the member to get that service in the hospital.
Q. More costly to BCBS of Massachusetts --
MR. COCO: Objection.
Q. -- and to the --
A. Ultimately to the member.
Q. Okay.
A. And the employer. But yes, we were -- we're the intermediary.
Q. In other words, BCBS of Massachusetts would be paying more in reimbursement?
A. Could be paying more, right, depending on the setting -- at least that was a potential.
Q. Okay. Now, was Option 1 adopted?
A. No.
Q. Okay. Was -- were the reasons why Option

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and including the fact that the resistance from the oncology community would -- would not be created, and including the fact that there would be -- not be a shift to a methodology that had not yet been widely adopted, those benefits were determined to be sufficient to adopt Option 4.
MR. COCO: Objection.
A. I didn't -- I can't speak for anyone else in the room. I didn't really view them as benefits.
Q. Okay. In fact, my question was far too long. Let me rephrase it and break it down somewhat.
A. Okay.
Q. Okay. Based on what we've discussed today, one of the problems with adopting an ASP-based methodology would have been a shift -- a potential shift in the site of care from physicians' offices to the outpatient setting, right?
MR. COCO: Objection.
A. I would say that a potential outcome of

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lowering our payment for the drug was stated by the oncologists to be that they would then move the service to a hospital.
Q. Okay. And that was a concern at BCBS because of concerns over patient convenience and because of concerns over the higher cost of reimbursing in the hospital outpatient setting, right?
MR. COCO: Objection.
A. Potential, yeah.
Q. Okay. Now, another concern in shifting to ASP was resistance from the oncologist community.
MR. COCO: Objection.
A. I'm -- I don't know that resistance in and of itself was the -- was the concern that drove me. I understand the wording of the document. There are policies that we've adopted that physicians are not in agreement with. But I think the -- the fact that that resistance could potentially cause a change in CMS's reimbursement, which would then create a situation where we might be bouncing around, the effect of that resistance, potentially,

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on CMS was an unknown.
Q. Okay.
A. So, that was something that we wanted to know more about.
Q. So, in consideration of all of those issues -- well, withdraw that. So, those are some of the issues that you considered to be particularly germane to this decision, right?
MR. COCO: Objection.
A. Without naming them, I'm worried about just saying yes, so --
Q. Well, let me rephrase it. The concerns that you just described --
A. Yes.
Q. -- are the concerns that you considered particularly germane to this decision.
MR. COCO: Objection.
A. The potential for CMS to change their methodology and the potential for there to be an adverse impact on our members, either in convenience or cost, that was unknown.
Q. And in making the final decision, you

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weighed those concerns, right?
MR. COCO: Objection.
A. I didn't consider it a final decision.
Q. Let me --
A. I considered it a --
Q. Let me rephrase it. In making the decision in February of 2004 not to move at that time, you weighed those concerns against the concerns with the AWP benchmark that were described by other members of the group and are reflected in this documents.
MR. COCO: Objection.
A. I considered all of those factors.
Q. And you decided that, on balance, Option 4 was the best decision for that time.
MR. COCO: Objection.
A. I decided not to change our practice at the moment, or I felt we should decide not to change our practice, and the group agreed.
Q. Which involved the adoption of Option 4.
MR. COCO: Objection.
A. Which actually involved just continuing

EXHIBIT 16

BlueCross BlueShield of Massachusetts

Landmark Center
401 Park Drive
Boston, MA 02215-3326

Analysis of CMS Average Wholesale Price Reform

Reimbursement for Part B Drugs

Prepared by:

Actuarial Department

Product and Provider Financial Management

February 7, 2004

Reasons for Reform

- Physicians benefit from the "spread" between AWP and acquisition cost creating an overpayment for drugs and costs for Medicare.
- According to GAO and CMS, in 2001 Medicare overpaid Part B drugs by over $1billion.
- In 2002 Oncologists collected approximately $600 million in overpayments.
- Patients who pay a coinsurance are adversely affected by the inflated AWP
    - *Source: Committee on Ways and Means, Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Chairman Bill Thomas 2/26/2004*

Average Sales Price (ASP) Reform

The Medicare Modernization ACT has led to the creation of a new drug pricing system beginning January 1, 2004 to replace Medicare's current pricing system.

- **Phase 1:** CMS move from 95% of AWP to 85% of AWP and institutes an increase in drug administration codes effective January 1, 2004.

- **Phase 2:** CMS institutes a new drug pricing system based on the Average Sales (ASP) price of a drug with additional drug administration price increases effective January 1, 2005.

  - CMS's new system, the Average Sales Price (ASP), has been developed to reflect drug prices more accurately.

  - Standard payment rate for most Part B drugs will be set at 106% of the ASP.

  - The ASP Method will be applied to drugs supplied under the DME benefit, certain oral anti-cancer drugs and oral immunosuppressive drugs.

Sources: 1) Federal Register/Vol. 69, No. 179/Thursday, September 16, 2004/Rules and Regs.
2) Private Payer News, Vol. 1, No. 9, October 2004

Average Sales Price Determination

- **Quarterly Calculation of Manufacturer's ASP:**

  CMS is requiring all drug manufacturers to submit to them, on a quarterly basis, data to determine the Average Sales Price for the drugs they sell.

  A Manufacturer's Average Sales price is calculated by taking total US Sales for a drug and dividing it by number of units sold.

  The following components are removed from the total sales calculation:

  - volume discounts
  - prompt pay discounts
  - cash discounts
  - free goods contingent on purchase requirement
  - charge backs and rebates

Sources: 1) Federal Register/Vol. 69, No. 179/Thursday, September 16, 2004/Rules and Regs.

Drug Admin Pricing Increases

- The ASP pricing changes will have adverse affects on physician organizations' profitability in particular Oncology/Hematology physician organizations.

- MD fee schedule payments for oncologists and other specialties are increased to accurately pay MDs for the cost of administering drugs.

  – *Source: Committee on Ways and Means, Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Chairman Bill Thomas 2/26/2004*

Drug Admin Fee Schedule Used for Analysis

Drug Administration - Fee Schedule

Proc Code	Description	Current BCBSMA Fee	CMS Fees	% Increase
90471	Immunization admin	$9.00	$26.27	192%
90472	Immunization admin, each add	$9.00	$15.51	72%
90473	Immune admin oral/nasal	$9.00	$26.27	192%
90474	Immune admin oral/nasal addl	$9.00	$15.51	72%
90780	IV infusion therapy, 1 hour	$54.07	$127.12	135%
90781	IV infusion, additional hour	$27.51	$35.35	28%
90782	Injection, sc/im	$5.53	$26.81	385%
90783	Injection, ia	$20.08	$26.61	33%
90784	Injection, iv	$23.23	$53.61	131%
90788	Injection of antibiotic	$6.00	$23.59	293%
96400	Chemotherapy, sc/im	$48.29	$69.75	44%
96405	Intralesional chemo admin	$145.04	$152.90	5%
96408	Chemotherapy, push technique	$47.59	$167.57	252%
96410	Chemotherapy,infusion method	$75.28	$235.37	213%
96412	Chemo, infuse method add-on	$55.97	$51.42	-8%
96414	Chemo, infuse method add-on	$65.30	$292.27	348%
96425	Chemotherapy,infusion method	$69.58	$252.01	262%
96520	Port pump refill & main	$43.79	$215.39	392%
96530	Syst pump refill & main	$51.40	$155.26	202%

Note: CMS Fees are an estimate of BCBSMA fee schedule pricing levels if the new CMS methodology was adopted. The estimate does not take into consideration the applicable BCBSMA conversion factor yet to be determined.

Impact to BCBSMA of New CMS Drug Pricing

- Drug Claims Data Set:
  - 6 months physician claims data.
  - Products: (HMO, POS, PPO, FEP, Indem, MCare Risk, MSP, Blue Card)

- Total Annualized Impact:
  - For the purposes of the CMS Drug Administration Pricing Analysis, drug codes 90471, 90472, 90473 and 90474 were maintained at Current BCBSMA Fee Levels ($9.00)

	Current BCBSMA Levels	Medicare Reform Levels	Impact	Budget Neutral Multipliers
Drug Supply Totals	**$38,171,174**	**$28,058,946**	**-$10,112,228**	**1.36**
Drug Admin Totals	**$6,917,059**	**$11,018,711**	**$4,101,652**	**0.63**
Total Costs	**$45,088,233**	**$39,077,657**	**-$6,010,576**	

Drug Code Reform Impact

Top 10 Total Dollar Impact by Type/Spec

Drug Code Impact Analysis by Type and Specialty

Analysis of the financial impact on each Type and Specialty of implementing Medicare ASP+6% pricing

Type Spec	Narrative	Annual Charges	BCBSMA Current Fee	Medicare Reform Levels ASP+6%	Difference	% Diff
2059	Oncology/Hematology	$31,457,860	$17,897,637	$13,660,714	-$4,236,923	-23.67%
2034	Urology	$4,814,666	$3,721,323	$1,918,398	-$1,802,925	-48.45%
2011	Internal Medicine	$8,461,321	$5,777,537	$4,432,738	-$1,344,799	-23.28%
2003	Allergy & Immunology	$2,430,699	$1,976,254	$1,018,441	-$957,813	-48.47%
2042	Rheumatology	$5,492,018	$4,121,317	$3,333,336	-$787,982	-19.12%
2007	Dermatology	$1,259,017	$657,366	$420,195	-$237,171	-36.08%
2010	Gastroenterology	$1,542,308	$1,071,737	$860,074	-$211,663	-19.75%
2006	Cardiovascular Disease	$282,474	$241,305	$144,541	-$96,764	-40.10%
2020	Orthopedic Surgery	$1,287,789	$741,555	$664,361	-$77,194	-10.41%
2039	Nephrology	$297,316	$231,206	$179,374	-$51,832	-22.42%
	Top 10 Totals:	**$57,325,467**	**$36,437,236**	**$26,632,172**	**-$9,805,064**	**-26.91%**
	All other Types and Specialties:	**$2,467,386**	**$1,733,939**	**$1,426,775**	**-$307,164**	**-17.71%**
	Total Amounts:	**$59,792,854**	**$38,171,174**	**$28,058,946**	**-$10,112,228**	**-26.49%**

Admin Code Reform Impact
Top 10 Type/Spec

Drug Administration Code Analysis - Drug Administration Type and Specialty Impact Analysis

Type Spec	Narrative	Charges	BCBSMA Current Fee	Medicare Reform Levels	Difference	% Difference
2059	Oncology/Hematology	$6,874,292	$1,722,922	$4,072,463	$2,349,541	136.37%
2011	Internal Medicine	$1,929,242	$740,293	$1,669,960	$929,667	125.58%
2016	Obstetrics/Gynecology	$183,022	$46,623	$201,080	$154,458	331.29%
2042	Rheumatology	$449,853	$154,611	$300,756	$146,145	94.52%
2008	Family Practice	$553,281	$253,332	$352,354	$99,022	39.09%
2003	Allergy & Immunology	$245,167	$71,566	$135,394	$63,827	89.19%
2035	**Pediatric**	**$6,642,266**	**$3,527,707**	**$3,575,901**	**$48,194**	**1.37%**
2001	General Practice	$71,099	$40,146	$83,917	$43,771	109.03%
2034	Urology	$125,440	$71,371	$111,362	$39,990	56.03%
2010	Gastroenterology	$113,500	$40,863	$80,172	$39,309	96.20%
	Top 10 Totals:	**$17,187,163**	**$6,669,433**	**$10,583,358**	**$3,913,925**	**58.68%**
	All other Types and Specialties:	**$577,137**	**$247,626**	**$435,353**	**$187,727**	**75.81%**
	Total Amounts:	**$17,764,300**	**$6,917,059**	**$11,018,711**	**$4,101,652**	**59.30%**

Total Reform Type/Spec Impact

Drug and Administration Code Analysis - Total Type and Specialty Impact Analysis

Type Spec	Narrative	Annual Charges	Current BCBSMA Levels	Medicare Drug Only Reform Levels	Difference	% Difference
2059	Oncology/Hematology	$38,332,152	$19,620,558	$17,733,177	-$1,887,382	-9.62%
2034	Urology	$4,940,107	$3,792,694	$2,029,760	-$1,762,934	-46.48%
2003	Allergy & Immunology	$2,675,866	$2,047,820	$1,153,835	-$893,986	-43.66%
2042	Rheumatology	$5,941,872	$4,275,928	$3,634,092	-$641,836	-15.01%
2011	Internal Medicine	$10,390,563	$6,517,829	$6,102,698	-$415,131	-6.37%
2007	Dermatology	$1,368,768	$700,678	$493,657	-$207,021	-29.55%
2010	Gastroenterology	$1,655,808	$1,112,600	$940,246	-$172,354	-15.49%
2020	Orthopedic Surgery	$1,288,251	$741,835	$665,577	-$76,258	-10.28%
2006	Cardiovascular Disease	$325,707	$261,377	$191,476	-$69,901	-26.74%
2039	Nephrology	$323,974	$239,409	$202,157	-$37,252	-15.56%
	Top 10 Totals:	**$67,243,068**	**$39,310,728**	**$33,146,674**	**-$6,164,054**	**-15.68%**
	All other Types and Specialties:	**$10,314,086**	**$5,777,505**	**$5,930,983**	**$153,478**	**2.66%**
	Total Amounts:	**$77,557,154**	**$45,088,233**	**$39,077,657**	**-$6,010,576**	**-13.33%**

Drug Reform Coding Impact

Top 10 Codes Based On Total Dollar Impact

Analysis of the financial impact of implementing Medicare ASP+6% pricing

Proc	Description	Charges	BCBSMA Current Fee	Avg Allow	CY 2004 2nd Quarter ASP+6%	Allowed @ ASP+6%	Difference	% Difference
J1563	IV immune globulin	$4,313,568	$2,966,332	$75.90	$38.02	$1,529,012	-$1,437,320	-48.45%
J9217	Leuprolide acetate suspnsion	$3,267,996	$2,514,258	$566.54	$242.26	$1,088,716	-$1,425,542	-56.70%
J1745	Infliximab injection	$8,919,852	$6,845,546	$65.64	$53.28	$5,551,456	-$1,294,089	-18.90%
J9265	Paclitaxel injection	$1,989,454	$1,162,525	$164.51	$17.84	$134,192	-$1,028,333	-88.46%
Q0136	Non esrd epoetin alpha inj	$5,671,079	$3,455,236	$12.98	$10.34	$2,750,357	-$704,879	-20.40%
J9202	Goserelin acetate implant	$1,246,349	$1,037,128	$427.47	$216.10	$533,335	-$503,793	-48.58%
J2505	Injection, pegfilgrastim 6mg	$4,028,356	$2,673,585	$2,811.80	$2,277.58	$2,172,811	-$500,774	-18.73%
J2430	Pamidronate disodium /30 MG	$679,231	$484,947	$269.29	$57.63	$105,117	-$379,830	-78.32%
J0880	Darbepoetin alfa injection	$2,876,733	$1,489,248	$24.67	$18.45	$1,159,841	-$329,407	-22.12%
J9310	Rituximab cancer treatment	$2,358,183	$1,620,685	$489.35	$438.38	$1,415,967	-$204,717	-12.63%
	Top 10 Codes:	**$35,350,800**	**$24,249,490**			**$16,440,806**	**-$7,808,684**	**-32.20%**
	All other codes:	**$24,442,053**	**$13,921,685**			**$11,618,140**	**-$2,303,544**	**-16.55%**
	Total Amounts:	**$59,792,854**	**$38,171,174**			**$28,058,946**	**-$10,112,228**	**-26.49%**

Option 1:

- Move to CMS ASP with changes in Admin Fees
  - Pros:
    - Administratively easy to maintain
    - Every provider is paid in the same way
    - Consistency among all product lines (Commercial, BC65 reimbursed using the same methodology)
  - Cons:
    - High impact to certain provider types (i.e., Oncology)
    - Resistance to changes by network
    - Potential shift to facility setting (Oncologists)
    - Uncertain future of CMS continuing with this payment methodology
  - Total Impact: -$6,010,576

Option 2

- Move to a **Budget Neutral** CMS ASP Methodology without changes in Administration Fees

  - This option would include adopting the CMS ASP Drug Fee Methodology while applying a **"multiplier"** to the fees. This option would allow BCBSMA to adopt the CMS ASP Methodology without reducing the total payments for drugs on a network-wide basis.

    - Pro:
      - Follow CMS's standard drug methodology
      - Overall Budget Neutrality to BCBSMA
      - Source for pricing updates

    - Con:
      - Although this methodology is budget neutral on a network-wide basis, some specialties may be adversely affected (i.e. – oncologists)

  - Budget Neutral Drug Code Multiplier: 1.36

Option 3:

- Maintain current 95% of 2004 CMS AWPs
  - Pros:
    - Never Update
    - No major system changes
  - Cons:
    - Stagnant Drug Fees
    - Not following standard set by CMS
  - Total Impact: $0

Option 4:

- Find drug vendor who can supply AWP's on a "J" Code Level.
  - Pros:
    - Can maintain current 95% of AWP methodology and level
    - Can be updated quarterly
    - Can set the percentage of AWP to whatever we find appropriate
  - Cons:
    - Does not follow CMS method
    - Drug Administration Fees will not increase

Next Steps

- Need decision/direction on physician drug reimbursement methodology
- Does BC65 have to follow CMS's drug payment methodology
- Timing – implementation date of change
- Notice to network